		FOR OHF USE					

LL1

2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0042499

Facility Name: MCKINLEY COURT

Address: 500 WEST MCKINLEY AVE. (Number) DECATUR (City) 62526 (Zip Code)

County: MACON

Telephone Number: (847) 875-0020 **Fax #** (847) 875-9434

IDPA ID Number: 36-4121313

Date of Initial License for Current Owners: 02/01/97

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
		X	Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: BOB KAGDA **Telephone Number:** (847) 675-3585

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2001 to 12/31/2001 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) SHAEL BELLOWS
(Title) MANAGEMENT CONSULTANT

Paid Preparer

(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT) (Date)
(Print Name and Title) BOB KAGDA, PARTNER
(Firm Name & Address) KRUPNICK BOKOR KAGDA & BROOKS, LTD, 3750 W DEVON AVE, LINCOLNWOOD, IL 60712-1124
(Telephone) (847) 675-3585 Fax # (847) 675-5777

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number MCKINLEY COURT # 0042499 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	150	Skilled (SNF)	150	54,750	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	150	TOTALS	150	54,750	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	6,099	2,751	7,475	16,325	8
9	SNF/PED					9
10	ICF	22,295	10,082	1,865	34,242	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	28,394	12,833	9,340	50,567	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 92.36%

D. How many bed-hold days during this year were paid by Public Aid?
338 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 02/01/97

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 02/01/97 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 22 and days of care provided 6,230

Medicare Intermediary MUTUAL OF OMAHA

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/01 Fiscal Year: 12/31/01

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number MCKINLEY COURT # 0042499 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	227,302	26,223	9,996	263,521		263,521	1,256	264,777			1
2	Food Purchase		198,966		198,966		198,966	(1,185)	197,781			2
3	Housekeeping	178,449	30,216	0	208,665		208,665	(3,425)	205,240			3
4	Laundry	90,721	23,482	1,709	115,912		115,912	(36)	115,876			4
5	Heat and Other Utilities			133,784	133,784		133,784	0	133,784			5
6	Maintenance	44,796	31,309	49,452	125,557		125,557	(6,075)	119,482			6
7	Other (specify):*			11,186	11,186		11,186	0	11,186			7
8	**TOTAL General Services**	541,268	310,196	206,127	1,057,591	0	1,057,591	(9,465)	1,048,126			8
	B. Health Care and Programs											
9	Medical Director	0		28,750	28,750		28,750	0	28,750			9
10	Nursing and Medical Records	1,386,397	115,562	23,117	1,525,076		1,525,076	789	1,525,865			10
10a	Therapy	93,504		9,140	102,644		102,644	0	102,644			10a
11	Activities	99,479	2,635	13,554	115,668		115,668	(1,239)	114,429			11
12	Social Services	37,820		4,591	42,411		42,411	0	42,411			12
13	Nurse Aide Training			0	0		0	0	0			13
14	Program Transportation			366	366		366	0	366			14
15	Other (specify):*				0		0	0	0			15
16	**TOTAL Health Care and Programs**	1,617,200	118,197	79,518	1,814,915	0	1,814,915	(450)	1,814,465			16
	C. General Administration											
17	Administrative	72,361		468,104	540,465		540,465	(454,683)	85,782			17
18	Directors Fees			0	0		0	0	0			18
19	Professional Services			167,359	167,359		167,359	3,115	170,474			19
20	Dues, Fees, Subscriptions & Promotions			81,714	81,714		81,714	(61,725)	19,989			20
21	Clerical & General Office Expenses	126,271	25,347	59,317	210,935		210,935	98,389	309,324			21
22	Employee Benefits & Payroll Taxes			604,858	604,858		604,858	0	604,858			22
23	Inservice Training & Education			1,051	1,051		1,051	0	1,051			23
24	Travel and Seminar			3,808	3,808		3,808	9,730	13,538			24
25	Other Admin. Staff Transportation			7,540	7,540		7,540	0	7,540			25
26	Insurance-Prop.Liab.Malpractice			9,052	9,052		9,052	3,124	12,176			26
27	Other (specify):*			23,810	23,810		23,810	(23,810)	0			27
28	**TOTAL General Administration**	198,632	25,347	1,426,613	1,650,592	0	1,650,592	(425,860)	1,224,732			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,357,100	453,740	1,712,258	4,523,098	0	4,523,098	(435,775)	4,087,323			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number MCKINLEY COURT #0042499 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			46,847	46,847		46,847	87,124	133,971			30
31	Amortization of Pre-Op. & Org.				0		0	0	0			31
32	Interest			102,443	102,443		102,443	267,780	370,223			32
33	Real Estate Taxes			24,486	24,486		24,486	0	24,486			33
34	Rent-Facility & Grounds			563,506	563,506		563,506	(556,514)	6,992			34
35	Rent-Equipment & Vehicles			15,903	15,903		15,903	6,294	22,197			35
36	Other (specify):* STORAGE			2,482	2,482		2,482	0	2,482			36
37	**TOTAL Ownership**			755,667	755,667	0	755,667	(195,316)	560,351			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation				0		0	0	0			38
39	Ancillary Service Centers		94,639	389,959	484,598		484,598	0	484,598			39
40	Barber and Beauty Shops				0		0	0	0			40
41	Coffee and Gift Shops				0		0	0	0			41
42	Provider Participation Fee			82,125	82,125		82,125	0	82,125			42
43	Other (specify):*				0		0	0	0			43
44	**TOTAL Special Cost Centers**	0	94,639	472,084	566,723	0	566,723	0	566,723			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,357,100	548,379	2,940,009	5,845,488	0	5,845,488	(631,091)	5,214,397			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number MCKINLEY COURT # 0042499 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(24,647)	30		9
10	Interest and Other Investment Income	(38,377)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,185)	2		13
14	Non-Care Related Interest	0	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)		25		16
17	Non-Care Related Fees	0	20		17
18	Fines and Penalties	(426)	21		18
19	Entertainment	(22,185)	20		19
20	Contributions	(1,310)	20		20
21	Owner or Key-Man Insurance	0	22		21
22	Special Legal Fees & Legal Retainers	(1,776)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(23,810)	27		24
25	Fund Raising, Advertising and Promotional	(32,431)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(7,559)	20		28
29	Other-Attach Schedule SEE PAGE 5A	(20,024)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (173,730)		$ 0	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(457,361)	PG 6&6A	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (457,361)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (631,091)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

MCKINLEY COURT

ID# 0042499

Report Period Beginning: 01/01/2001

Ending: 12/31/2001

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	$ -5660	6	1
2	VACATION ACCRUAL	1,256	1	2
3	VACATION ACCRUAL	(3,425)	3	3
4	VACATION ACCRUAL	(36)	4	4
5	VACATION ACCRUAL	(415)	6	5
6	VACATION ACCRUAL	(8,517)	10	6
7	VACATION ACCRUAL	(1,239)	11	7
8	VACATION ACCRUAL	(766)	17	8
9	VACATION ACCRUAL	(1,222)	21	9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(20,024)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number MCKINLEY COURT # 0042499 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	1,256	0	0	0	0	0	0	0	0	0	0	1,256	1
2	Food Purchase	(1,185)	0	0	0	0	0	0	0	0	0	0	(1,185)	2
3	Housekeeping	(3,425)	0	0	0	0	0	0	0	0	0	0	(3,425)	3
4	Laundry	(36)	0	0	0	0	0	0	0	0	0	0	(36)	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	(6,075)	0	0	0	0	0	0	0	0	0	0	(6,075)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(9,465)	0	0	0	0	0	0	0	0	0	0	(9,465)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(8,517)	9,306	0	0	0	0	0	0	0	0	0	789	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(1,239)	0	0	0	0	0	0	0	0	0	0	(1,239)	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	(9,756)	9,306	0	0	0	0	0	0	0	0	0	(450)	16
	C. General Administration													
17	Administrative	(766)	(453,917)	0	0	0	0	0	0	0	0	0	(454,683)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(1,776)	4,516	375	0	0	0	0	0	0	0	0	3,115	19
20	Fees, Subscriptions & Promotions	(63,485)	1,760	0	0	0	0	0	0	0	0	0	(61,725)	20
21	Clerical & General Office Expenses	(1,648)	100,037	0	0	0	0	0	0	0	0	0	98,389	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	9,730	0	0	0	0	0	0	0	0	0	9,730	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	3,124	0	0	0	0	0	0	0	0	0	3,124	26
27	Other (specify):*	(23,810)	0	0	0	0	0	0	0	0	0	0	(23,810)	27
28	**TOTAL General Administration**	(91,485)	(334,750)	375	0	0	0	0	0	0	0	0	(425,860)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(110,706)	(325,444)	375	0	0	0	0	0	0	0	0	(435,775)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number MCKINLEY COURT # 0042499 **Report Period Beginning:** 01/01/2001 **Ending:** 12/31/2001

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(24,647)	5,000	106,771	0	0	0	0	0	0	0	0	87,124	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(38,377)	0	306,157	0	0	0	0	0	0	0	0	267,780	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	6,992	(563,506)	0	0	0	0	0	0	0	0	(556,514)	34
35	Rent-Equipment & Vehicles	0	6,294	0	0	0	0	0	0	0	0	0	6,294	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(63,024)	18,286	(150,578)	0	0	0	0	0	0	0	0	(195,316)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(173,730)	(307,158)	(150,203)	0	0	0	0	0	0	0	0	(631,091)	45

Facility Name & ID Number MCKINLEY COURT # 0042499 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SEE ATTACHED LIST OF		SEE ATTACHED LIST OF RELATED		FIRST HEALTH CARE ASSOCIATES, LTD		MANAGEMENT/
OWNERS		NURSING HOMES		(DIVISION OF FHC ENTERPRISE, INC.)		CONSULTANT
					ROSEMONT	
				LANDMARK PROPERTIES		
					ROSEMONT	REAL ESTATE

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	10	NURSING	$	FHC ENTERPRISES INC.		$ 9,306	$ 9,306	1
2	V	17	ADMINISTRATIVE	468,104	MR. BELLOWS OWNS 62.5% OF THIS FACILITY		14,187	(453,917)	2
3	V	19	PROFESSIONAL FEES		AND 100% OF FHC ENTERPRISES		4,516	4,516	3
4	V	20	DUES & SUBSCRIPTIONS		" "		1,760	1,760	4
5	V	21	CLERICAL		" "		100,037	100,037	5
6	V	24	TRAVEL		" "		9,730	9,730	6
7	V	26	INSURANCE		" "		3,124	3,124	7
8	V	30	DEPRECIATION		" "		5,000	5,000	8
9	V	34	RENT		" "		6,992	6,992	9
10	V	35	RENT-EQUIPMENT & VEH.		" "		6,294	6,294	10
11	V								11
12	V								12
13	V								13
14	Total			$ 468,104			$ 160,946	$ * (307,158)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number MCKINLEY COURT # 0042499 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	34	RENT	$ 563,506	LANDMARK PROPERTIES		$	$ (563,506)	15
16	V	19	OTHER PROFESSIONAL		" "		375	375	16
17	V	30	DEPRECIATION-BLDG/IMPROV.		" "		86,618	86,618	17
18	V	30	DEPRECIATION-EQUIPMENT		" "		20,153	20,153	18
19	V	32	INTEREST-MORTGAGE		" "		302,157	302,157	19
20	V	32	AMORTIZATION-MTG COST		" "		4,000	4,000	20
21	V				" "				21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 563,506			$ 413,303	$ * (150,203)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number MCKINLEY COURT # 0042499 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	RELATED PARTY - FHC ENTERPRISES INC.								$		1
2	SHAEL BELLOWS	MNGMT CNSLT.	ADMIN.	62.50	SEE ATTACHED	1.9	10.05	SALARY	14,187	17-7	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 14,187		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number MCKINLEY COURT # 0042499 Report Period Beginning: 01/01/2001 Ending: 2/31/2001

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: FHC ENTERPRISES, INC.
Street Address: 10700 W. HIGGINS ROAD, STE 300
City / State / Zip Code: ROSEMONT, IL 60018
Phone Number: (847) 296-9625
Fax Number: (847) 298-0824

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	10	NURSING	PATIENT DAYS	501,904	10	$ 92,369	$ 92,369	50,567	$ 9,306	1
2	17	ADMINISTRATIVE	PATIENT DAYS	501,904	10	140,817	140,817	50,567	14,187	2
3	19	PROFESSIONAL FEES	PATIENT DAYS	501,904	10	44,800		50,567	4,516	3
4	20	DUES AND SUBSCRIPTIONS	PATIENT DAYS	501,904	10	17,462		50,567	1,760	4
5	21	CLERICAL	PATIENT DAYS	501,904	10	130,659		50,567	13,164	5
6	21	CLERICAL	DIRECT COST	1	1	86,867		1	86,873	6
7	24	TRAVEL	PATIENT DAYS	501,904	10	96,528		50,567	9,730	7
8	26	INSURANCE	PATIENT DAYS	501,904	10	30,995		50,567	3,124	8
9	30	DEPRECIATION	PATIENT DAYS	501,904	10	49,603		50,567	5,000	9
10	34	RENT	PATIENT DAYS	501,904	10	69,364		50,567	6,992	10
11	35	RENT-EQUIPMENT & VEH	PATIENT DAYS	501,904	10	62,438		50,567	6,294	11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 821,902	$ 233,186		$ 160,946	25

Facility Name & ID Number MCKINLEY COURT # 0042499 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	RELATED PARTY - LANDMARK PROPERTIES						$	$			$	1
2	AMERICAN NATIONAL BK		X	MORTGAGE	VARIES	02/97	4,000,000	3,611,051		PRIME+	302,157	2
3	LOAN COSTS		X	LOAN COSTS			20,000	19,667			4,000	3
4												4
5												5
	Working Capital											
6	AMERICAN NATIONAL BK		X	WORKING CAPITAL	VARIES	12/98	500,000	500,000	DEMAND	PRIME+	27,963	6
7	NORTHWOODS CARE CNTR	X		WORKING CAPITAL	VARIES	12/99	475,000	802,841	DEMAND	VARIES	74,480	7
8												8
9	TOTAL Facility Related						$ 4,995,000	$ 4,933,559			$ 408,600	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$ 0	$ 0			$ 0	14
15	TOTALS (line 9+line14)						$ 4,995,000	$ 4,933,559			$ 408,600	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number MCKINLEY COURT # 0042499 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2000 report.	$	155,100	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	31,866	2
3. Under or (over) accrual (line 2 minus line 1).	$	(123,234)	3
4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)	$	147,720	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ ____ For 19 ____ Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	24,486	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1996		8
	1997		9
	1998		10
	1999		11
	2000	31,866	12

THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 101% OF THE PRIOR YEAR REAL ESTATE TAX BILL

THE PAYMENT ON LINE 2 APPLIES TO THE 2000 TAX BILL.

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2000	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity. This denial must be no more than four years old at the time the cost report is filed.**

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME MCKINLEY COURT COUNTY MACON

FACILITY IDPH LICENSE NUMBER 0042499

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

TELEPHONE (847) 675-3585 FAX #: (847) 675-5777

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	04-12-03-251-011	NURSING HOME	$ 75,203.86	$ 31,866.04
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 75,203.86	$ 31,866.04

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? X YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number MCKINLEY COURT # 0042499 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 60,100 B. General Construction Type: Exterior BRICK Frame WOOD Number of Stories 1

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	NURSING HOME	119,790	1997	$	1
2					2
3	TOTALS	119,790		$ 0	3

Facility Name & ID Number MCKINLEY COURT # 0042499 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	150		1997		$ 1,872,313	$ 68,084	27.5	$ 68,084	$	$ 338,930	4
5			1998		95,000	3,455	27.5	3,455		13,675	5
6											6
7											7
8											8
	Improvement Type**										
9	RELATED PARTY - LANDMARK PROPERTIES										9
10	OUTDOOR SIGNS			1997	24,046	874	27.5	874		3,897	10
11	REPLACE, REPAIR AND SEAL PAVEMENT			1998	6,754	577	15	450	(127)	1,575	11
12	REPLACE BLACK VALLEYS			1999	5,875	214	27.5	214		526	12
13	WALLCOVERING/CARPETING/WINDOW TMTS			1999	154,975	5,635	27.5	5,635		13,853	13
14	SPRINKLER SYSTEMS			1999	4,744	173	27.5	173		425	14
15	REMODELING - ARCHITECT FEE			1999	5,975	1,195	5	1,195		2,390	15
16	RESIDENT ROOMS/BATHROOMS-PAINTING			2000	13,710	4,570	3	4,570		6,855	16
17	FIRE ALARM CONTROL PANEL			2000	6,703	1,341	5	1,341		2,011	17
18	REMODELING - ARCHITECT FEE			2000	1,493	100	15	100		150	18
19	PAINTING-S/E CORRIDOR/SMOKING RM/NURSES STATIONS			2001	7,382	527	7	527		527	19
20											20
21					ADJ TO SL	(127)			127		21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number MCKINLEY COURT # 0042499 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 2,198,970	$ 86,618		$ 86,618	$ 0	$ 384,814	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number MCKINLEY COURT # 0042499 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 277,237	$ 44,330	$ 21,571	$ (22,759)	3-15 YRS	$ 52,886	71
72	Current Year Purchases	12,589	2,517	629	(1,888)	3-15 YRS	629	72
73	Fully Depreciated Assets				0			73
74	RELATED PARTIES	298,295	25,153	25,153	0		71,104	74
75	TOTALS	$ 588,121	$ 72,000	$ 47,353	$ (24,647)		$ 124,619	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$ 0		$	76
77							0			77
78							0			78
79							0			79
80	TOTALS			$ 0	$ 0	$ 0	$ 0		$ 0	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 2,787,091	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 158,618	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 133,971	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (24,647)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 509,433	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number MCKINLEY COURT # 0042499 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A - RELATED PARTY

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease ____.

9. Option to Buy: ☐ YES ☐ NO Terms: ____ *

10. Effective dates of current rental agreement:
Beginning ____
Ending ____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2002	$
13.	/2003	$
14.	/2004	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ NO

16. Rental Amount for movable equipment: $ 12,778 Description: SEE SCHEDULE ATTACHED
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	FACILITY USE	99 DODGE DURANGO	$ 625.00	$ 3,125	17
18					18
19					19
20					20
21	TOTAL		$ 625.00	$ 3,125	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number MCKINLEY COURT # 0042499 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [ ] YES [X] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$ 0
2	Books and Supplies				0
3	Classroom Wages (a)				0
4	Clinical Wages (b)				0
5	In-House Trainer Wages (c)				0
6	Transportation				0
7	Contractual Payments				0
8	Nurse Aide Competency Tests				0
9	TOTALS	$ 0	$ 0	$ 0	$ 0
10	SUM OF line 9, col. 1 and 2 (e)	$ 0			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39-3	hrs	$		$ 190,108	$		$ 190,108	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			11,376			11,376	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			188,475			188,475	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				81,208		81,208	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	RENTALS, LAB, IV THERAPY Other (specify):	39-2					13,431		13,431	13
14	TOTAL			$		$ 389,959	$ 94,639		$ 484,598	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number MCKINLEY COURT # 0042499 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2001 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 110,269	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 72,150)	903,446		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments	1,351		5
6	Prepaid Insurance	121,415		6
7	Other Prepaid Expenses	45,723		7
8	Accounts Receivable (owners or related parties)	1,064,064		8
9	Other(specify): EMPLY LOANS	750		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,247,018	$ 0	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	289,825		16
17	Accumulated Depreciation (book methods)	(172,444)		17
18	Deferred Charges	4,167		18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 121,548	$ 0	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,368,566	$ 0	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 276,179	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	31,089		28
29	Short-Term Notes Payable	1,302,841		29
30	Accrued Salaries Payable	110,753		30
31	Accrued Taxes Payable (excluding real estate taxes)	15,932		31
32	Accrued Real Estate Taxes(Sch.IX-B)	147,720		32
33	Accrued Interest Payable	66		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	MANAGEMENT FEES	392,512		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,277,092	$ 0	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 0	$ 0	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,277,092	$ 0	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 91,474	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,368,566	$ 0	48

*(See instructions.)

Facility Name & ID Number MCKINLEY COURT # 0042499 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 42,356	1
2	Restatements (describe):		2
3	ROUNDING	(6)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 42,350	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	49,124	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 49,124	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ 0	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 91,474	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number MCKINLEY COURT # 0042499 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 5,851,220	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,851,220	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 0	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	990	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 990	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	38,377	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 38,377	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	NET VENDING COMMISSIONS	4,025	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 4,025	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 5,894,612	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,057,591	31
32	Health Care	1,814,915	32
33	General Administration	1,650,592	33
	B. Capital Expense		
34	Ownership	755,667	34
	C. Ancillary Expense		
35	Special Cost Centers	484,598	35
36	Provider Participation Fee	82,125	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 5,845,488	40
41	**Income before Income Taxes (line 30 minus line 40)****	49,124	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 49,124	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return?** NO **If not, please attach a reconciliation.**
TAX RETURN PREPARED ON CASH BASIS

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number MCKINLEY COURT # 0042499 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,991	2,185	$ 55,992	$ 25.63	1
2	Assistant Director of Nursing	1,958	2,044	42,123	20.61	2
3	Registered Nurses	6,508	7,305	127,511	17.46	3
4	Licensed Practical Nurses	31,604	34,263	488,039	14.24	4
5	Nurse Aides & Orderlies	68,103	72,468	645,737	8.91	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	7,016	7,747	93,504	12.07	8
9	Activity Director	3,758	4,114	57,442	13.96	9
10	Activity Assistants	5,158	5,695	42,037	7.38	10
11	Social Service Workers	3,736	4,048	37,820	9.34	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	13,088	14,468	130,104	8.99	14
15	Cook Helpers/Assistants	13,879	14,714	97,198	6.61	15
16	Dishwashers					16
17	Maintenance Workers	2,792	3,249	44,796	13.79	17
18	Housekeepers	19,444	21,269	178,449	8.39	18
19	Laundry	13,591	13,938	90,721	6.51	19
20	Administrator	1,950	2,227	72,361	32.49	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	8,719	9,411	126,271	13.42	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,945	2,150	26,995	12.56	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	205,240	221,295	$ 2,357,100 *	$ 10.65	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	185	$ 9,996	1-3	35
36	Medical Director	351	28,750	9-3	36
37	Medical Records Consultant	30	1,170	10-3	37
38	Nurse Consultant	491	20,747	10-3	38
39	Pharmacist Consultant	168	1,200	10-3	39
40	Physical Therapy Consultant	92	4,624	10a-3	40
41	Occupational Therapy Consultant	88	4,516	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant		0	10a-3	43
44	Activity Consultant	64	4,238	11-3	44
45	Social Service Consultant	62	4,591	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	1,531	$ 79,832		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number MCKINLEY COURT # 0042499 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
TOM MULLINS	ADMIN		$ 72,361
			0
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 72,361

B. Administrative - Other

Description	Amount
FIRST HEALTHCARE - MANAGEMENT FEES	$ 468,104
TOTAL (agree to Schedule V, line 17, col. 3)	$ 468,104
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
		$
SEE SCHEDULE ATTACHED		167,359
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 167,359

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 38,007
Unemployment Compensation Insurance	35,818
FICA Taxes	174,546
Employee Health Insurance	332,738
Employee Meals	0
Illinois Municipal Retirement Fund (IMRF)*	
EMPLOYEE BENEFITS - OTHER	9,527
EMPLOYEE PHYSICAL EXAMS	7,203
PENSION/PROFIT SHARING PLANS	7,019
CHICAGO HEAD TAX	0
INSURANCE - EXECUTIVE LIFE	0
INSURANCE - EXECUTIVE LIFE VI 21	0
TOTAL (agree to Schedule V, line 22, col.8)	$ 604,858

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	5,977
Health Care Worker Background Check	372
(Indicate # of checks performed)	
MARKETING/ADV/PROMO	62,175
RELATED PARTY	1,760
CONTRIBUTIONS	1,310
DUES & SUBSCRIPTIONS	10,690
LICENSES & PERMITS	1,190
LESS: CONTRIBUTIONS	(1,310)
Less: Public Relations Expense	(22,185)
Non-allowable advertising	(32,431)
Yellow page advertising	(7,559)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 19,989

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
	3,808
RELATED PARTY	9,730
Seminar Expense	
	0
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 13,538

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number MCKINLEY COURT # 0042499 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006
1	PAINT/DECORATING	1998	$ 3,076	3	$ 513	$ 1,025	$ 1,025	$ 513	$	$	$	$	$
2	PAINT/DECORATING	1999	3,281	3		547	1,094	1,094	546				
3	PAINT/DECORATING	2000	2,965	3			494	988	988	495			
4	PAINT/DECORATING	2001	9,907	3				1,652	3,302	3,302	1,651		
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$ 19,229		$ 513	$ 1,572	$ 2,613	$ 4,247	$ 4,836	$ 3,797	$ 1,651	$	$

Facility Name & ID Number MCKINLEY COURT # 0042499 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? YES

(2) Are there any dues to nursing home associations included on the cost report? YES
If YES, give association name and amount. ILL.HEALTHCARE ASSOC. $8640

(3) Did the nursing home make political contributions or payments to a political action organization? YES If YES, have these costs been properly adjusted out of the cost report? YES

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 10 YR

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ 1,227 Line 10-2

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES X NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ 82,125
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ 0 Has any meal income been offset against related costs? N/A Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? 5%
d. Have vehicle usage logs been maintained? NO
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? NO
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? YES
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? NO
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? YES
Attach invoices and a summary of services for all architect and appraisal fees.

Facility Name & ID#: MCKINLEY COURT **#0042499** **Report Period Beginning: 01/01/2001** **Ending: 12/31/2001**

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
1	**DIETARY**			
	DIETITIAN CONSULTANT	XVIII B 35-2	9,996	
	REPAIRS & MAINTENANCE		0	
			0	9,996
3	**HOUSEKEEPING**			
			0	
			0	0
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE		1,709	
			0	1,709
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		33,335	
	ELECTRICITY		90,560	
	WATER		9,889	
	CABLE TV - LOBBY		0	
			0	133,784
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		13,644	
	PAINTING & DECORATING		9,907	
	BUILDING REPAIRS		0	
	MAINTENANCE TRAVEL		0	
	EQUIPMENT MAINTENANCE & REPAIR		15,946	
	ELEVATOR MAINTENANCE & REPAIR		0	
	OUTSIDE LABOR		717	
	EXTERMINATING SERVICE		6,358	
	FIRE SERVICE		2,047	
	DEFERRED MAINTENANCE		833	
			0	
			0	49,452
7	**OTHER**			
	SCAVENGER		11,186	
	SECURITY SERVICE		0	11,186
9	**MEDICAL DIRECTOR**			
	MEDICAL DIRECTOR FEES	XVIII B 36-2	28,750	28,750

LINE		SCHED REF		TOTAL
10	**NURSING**			
	CONTRACT NURSING	XVIII C 53-2		
	LABORATORY & XRAY EXPENSE		0	
	PURCHASED SERVICES		0	
	PSYCHO-SOCIAL CONSULTANT	XVIII B __-2	0	
	RESTORATIVE NURSING CONSULTAN	XVIII B 38-2	0	
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	1,170	
	PHARMACY CONSULTANT	XVIII B 39-2	1,200	
	UTILIZATION REVIEW FEES	XVIII B __-2	0	
	PHYSICIANS	XVIII B __-2	0	
	PSYCHIATRIC	XVIII B __-2	0	
	RN CONSULTANT	XVIII B 38-2	20,747	
			0	
			0	23,117
10a	**THERAPY**			
	PHYSICAL THERAPY SERVICES		0	
	SPEECH THERAPY SERVICES		0	
	OCCUPATIONAL THERAPY SERVICES		0	
	REHABILITATION CONSULTANT	XVIII B __-2	0	
	PHYSICAL THERAPY CONSULTANT	XVIII B 40-2	4,624	
	OCCUPATIONAL THERAPY CONSULTA	XVIII B 41-2	4,516	
	RESPIRATORY THERAPY CONSULTAN	XVIII B 42-2	0	
	SPEECH THERAPY CONSULTANT	XVIII B 43-2	0	9,140
11	**ACTIVITIES**			
	CABLE TV - PATIENT ROOMS		9,316	
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	4,238	
			0	13,554
12	**SOCIAL SERVICES**			
	SOCIAL REHABILITATION SERVICES		0	
	SOCIAL REHABILITATION CONSULTAN	XVIII B 45-2	0	
	SOCIAL WORKER	XVIII B 45-2	4,591	
			0	4,591
13	**NURSE AIDE TRAINING**			
	NURSE AIDE TRAINING COSTS	XIII	0	0

Facility Name & ID Number MCKINLEY COURT **#0042499** **Report Period Beginning: 01/01/2001** **Ending: 12/31/2001**

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
14	**PROGRAM TRANSPORTATION**			
	PATIENT TRANSPORTATION		366	366
17	**ADMINISTRATIVE**			
	MANAGEMENT FEES	XIX B	468,104	468,104
18	**DIRECTORS FEES**		0	0
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	12,678	
	ADMINISTRATIVE CONSULTANTS	XIX C	0	
	PROFESSIONAL FEES	XIX C	154,681	
			0	167,359
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F	22,185	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	32,431	
	EMPLOYEE WANT ADS	XIX F	5,977	
	CONTRIBUTIONS	VI 20 XIX F	1,010	
	DUES & SUBSCRIPTIONS	XIX F	10,690	
	LICENSES & PERMITS	XIX F	1,190	
	PUBLIC RELATIONS-PATIENT RELATED	XIX F	0	
	ADVERTISING-YELLOW PAGES	VI 28 XIX F	7,559	
	TRUST FEES / FRANCHISE TAX / ETC	VI 17 XIX F	0	
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F	300	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F	372	81,714
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES		567	
	EQUIPMENT REPAIR & MAINTENANCE		6,480	
	OUTSIDE CLERICAL SERVICES		0	
	PENALTIES / OVERDRAFT CHARGES	VI 18	426	
	HOME OFFICE EXPENSE		0	
	THEFT & DAMAGE LOSS		182	
	TELEPHONE		49,404	
	MESSENGER SERVICE		2,258	
			0	59,317

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	174,546	
	UNEMPLOYMENT COMPENSATION	XIX D	35,818	
	WORKERS COMPENSATION INSURANC	XIX D	38,007	
	HOSPITALIZATION INSURANCE	XIX D	332,738	
	EMPLOYEE BENEFITS - OTHER	XIX D	9,527	
	EMPLOYEE PHYSICAL EXAMS	XIX D	7,203	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	0	
	PENSION/PROFIT SHARING PLANS	XIX D	7,019	
	CHICAGO HEAD TAX	XIX D	0	604,858
23	**INSERVICE TRAINING & EDUCATION**			
	EDUCATION & SEMINARS		1,051	1,051
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G	0	
	TRAVEL	XIX G	3,808	
			0	
			0	3,808
25	**ADMIN. STAFF TRANSPORTATION**			
	TRANSPORTATION - STAFF		7,540	7,540
26	**INSURANCE - PROP. LIAB & MALPRACTICE**			
	GENERAL INSURANCE		9,052	9,052
27	**OTHER**			
	BAD DEBTS	VI 24	23,810	
			0	23,810

GRAND TOTAL COLUMN 3 OTHER 1,712,258

MCKINLEY COURT
EMPLOYEE MEAL RECLASSIFICATION
12/31/2001

TOTAL FOOD PURCHASE	198,966
LESS SALES TAX	(1,185)
NET FOOD	200151
TOTAL PATIENT CENSUS	50,567
TIME 3 MEALS PER DAY	3
TOTAL PATIENT MEALS	151701
ADD # EMPLOYEE MEALS/DAY	0
TIME # DAYS	365
TOTAL EMPLOYEE MEALS	0

PATIENT MEALS	151701
ADD EMPLOYEE MEALS	0
TOTAL MEALS/YEAR	151701
NET FOOD	200151
DIVIDE TOTAL MEALS/YEAR	151701
COST PER MEAL	1.32
TIME EMPLOYEE MEALS	0
EMPLOYEE MEAL RECLASSIFICATION	0

MCKINLEY COURT
RECONCILIATION OF COST REPORT TO FINANCIAL STATEMENTS
12/31/2001

INCOME PER F/S										5,366,701	
		NURSING	EMPL BENEFITS	PLANT	LAUNDRY	DIETARY	GENL/ADMIN	OTHER INC/EXP	CAPITAL		SALARIES
PER COST REPORT		1,814,915	604,858	479,192	115,912	462,487	1,045,734	82,125	755,667		2,357,100
ADJUSTMENTS:											
	EQUIPMENT RENTAL/AUTO LEASE	4,660		4,398			6,845		(15,903)		
	CABLE TV			0			0				
	CONTRACT NURSING/COSTS REBILLED										21,623
	INTEREST INCOME							(38,377)			
	NET VENDING COMMISSIONS/VENDING							(5,015)			
	EMPLOYEE PHYSICAL EXAMS		(7,203)				7,203				
	INSURANCE - EXECUTIVE LIFE		0				0				
	MANAGEMENT FEES						(468,104)		468,104		
	RESIDENT TAX REBILLED - PVT										
	BAD DEBTS						(23,810)	23,810			
	DISCOUNTS LOST							0			
	AMORT-COMP SOFTWARE								0		
	SETTLEMENT INTEREST										
	RECLASSED SALARIES	(58,339)	0	0	0	0	58,339	0	0		
	PROFIT SHARING	0	0	0	0	0	0	0	0		
	PRIOR EXPENSES	0	0	0	0	0	0	79	0		
	BENEFITS REBILLED	0	0	0	0	0	0	0	0		
	RENT/INTEREST	0	0	0	0	0	0	0	0		
	NURSE AID REIMB-STATE	0	0	0	0	0	0	0	0		
TOTAL COSTS		1,761,236	597,655	483,590	115,912	462,487	626,207	62,622	1,207,868	5,317,577	2,378,723
PER FINANCIAL STATEMENTS		1,761,236	597,655	483,590	115,912	462,487	626,207	62,622	1,207,868	49,124	2,378,723
NET INCOME (LOSS) BEFORE INCOME TAXES PER FINANCIAL STATEMENTS										49,124	

MCKINLEY COURT - COMPARISONS - 12/31/2001

	ref.	12/31/2001			12/31/2000			DIFF	12/31/1999		
CAPACITY DAYS		54,750			54900			(150)	54750		
CENSUS DAYS		50,567			50732			(165)	49945		
OCCUPANCY %		92.36%			92.41%				91.22%		
SALARIES											
TOTAL General Services	8-1	541,268	10.38%	10.70	545474	11.59%	10.75	(4,206)	537641	12.50%	10.76
Social Services	12-1	37,820	0.73%	0.75	36378	0.77%	0.72	1,442	46149	1.07%	0.92
TOTAL Health Care and Programs	16-1	1,617,200	31.01%	31.98	1375336	29.23%	27.11	241,864	1279569	29.75%	25.62
Clerical & General Office Expenses	21-1	126,271	2.42%	2.50	130452	2.77%	2.57	(4,181)	79569	1.85%	1.59
TOTAL General Administration	28-1	198,632	3.81%	3.93	208091	4.42%	4.10	(9,459)	144464	3.36%	2.89
TOTAL Operation Expense	29-1	2,357,100	45.20%	46.61	2128901	45.24%	41.96	228,199	1961674	45.61%	39.28
ADJUSTED TOTALS											
Food	2-8	197,781	3.79%	3.91	188496	4.01%	3.72	9,285	177744	4.13%	3.56
Heat and Other Utilities	5-8	133,784	2.57%	2.65	126574	2.69%	2.49	7,210	110663	2.57%	2.22
Maintenance	6-8	119,482	2.29%	2.36	131702	2.80%	2.60	(12,220)	123663	2.88%	2.48
TOTAL General Services	8-8	1,048,126	20.10%	20.73	1028164	21.85%	20.27	19,962	981573	22.82%	19.65
Administrative	17-8	85,782	1.65%	1.70	94792	2.01%	1.87	(9,010)	77593	1.80%	1.55
Directors Fees	18-8	0	0.00%	0.00				0			
Professional Services	19-8	170,474	3.27%	3.37	202644	4.31%	3.99	(32,170)	173408	4.03%	3.47
Fees, Subscriptions, Promotions	20-8	19,989	0.38%	0.40	27460	0.58%	0.54	(7,471)	26121	0.61%	0.52
License Fee-IDPA	Pg21	0	0.00%	0.00	200	0.00%	0.00	(200)	200	0.00%	0.00
License Fee-Other	Pg21	1,190	0.02%	0.02	200	0.00%	0.00	990	475	0.01%	0.01
Clerical & General Office Expenses	21-8	309,324	5.93%	6.12	315751	6.71%	6.22	(6,427)	225996	5.25%	4.52
Employee Benefits & Payroll Taxes	22-8	604,858	11.60%	11.96	410787	8.73%	8.10	194,071	548464	12.75%	10.98
Payroll Taxes	Pg21	210,364	4.03%	4.16	188998	4.02%	3.73	21,366	185056	4.30%	3.71
W/C Insurance	Pg21	38,007	0.73%	0.75	32104	0.68%	0.63	5,903	38409	0.89%	0.77
Health Insurance	Pg21	332,738	6.38%	6.58	173213	3.68%	3.41	159,525	306279	7.12%	6.13
Inservice Training & Education	23-8	1,051	0.02%	0.02	7044	0.15%	0.14	(5,993)	5343	0.12%	0.11
Travel and Seminar	24-8	13,538	0.26%	0.27	12535	0.27%	0.25	1,003	7882	0.18%	0.16
Other Admin. Staff Transportation	25-8	7,540	0.14%	0.15	3623	0.08%	0.07	3,917	4844	0.11%	0.10
Insurance-Prop.Liab.Malpractice	26-8	12,176	0.23%	0.24	78665	1.67%	1.55	(66,489)	40845	0.95%	0.82
Other (specify):*	27-8	0	0.00%	0.00				0			
TOTAL General Administration	28-8	1,224,732	23.49%	24.22	1153301	24.51%	22.73	71,431	1110496	25.82%	22.23
TOTAL Operation Expense	29-8	4,087,323	78.39%	80.83	3727260	79.21%	73.47	360,063	3527952	82.03%	70.64
Real Estate Taxes	33-3	24,486	0.47%	0.48	39600	0.84%	0.78	(15,114)	39600	0.92%	0.79
Real Estate Legal	Pg10	0	0.00%	0.00				0			
GRAND TOTAL COST	45-8	5,214,397	100.00%	**103.12**	4705767	100.00%	**92.76**	508,630	4300772	100.00%	**86.11**
8-8 + (28-8 - 22-8) + 28-8*(8-1 + 28-1)/29-1		1857866.55	35.63%	**36.74**	1916084	40.72%	**37.77**	(58,217)	1734315	40.33%	**34.72**

MCKINLEY COURT - DIAGNOSTICS - 12/31/2001

This report reflects a 365-day year.
Page 3 Column 3 - Other is completely scheduled.
Total Salaries on Page 3 Line 29-1 = Page 20 Line 34-3.
Total Adj on Page 4 Line 45-7 = Page 5 Line 37.
Deferred maint. adj. on Page 5A Line 1 consists of 4247 from Page 22 and -9907 from Page 3 Line 6-3.
Ancillaries on Page 4 Line 39-6 = Page 16 Line 14-8.
Interest Expense on Page 4 Line 32-4 DOES NOT EQUAL Page 9 Line 15-10. Diff=-306157
Real estate tax expense on Page 4 Line 33-4 = Page 10 Line 7.
Real estate tax accrual on Page 10 Line 4 = Page 17 Line 32-1.
Depn expense on Page 4 Line 30-4 DOES NOT EQUAL Page 13 Line 82-2. Diff=-111771
Depreciation expense on Page 4 Line 30-8 = Page 13 Line 83-2.
Facility rent on Page 4 Line 34-4 DOES NOT EQUAL Page 14 Line 7-4.
Equipment rent on Page 4 Line 35-4 = Page 14 Line 16 + Line 21-4.
Nurse aide training on Page 3 Line 13-8 = Page 15 Line 9-4.
Total equity on Page 17 Line 47-1 = Page 18 Line 24-1.
Page 17 Assets = Liabilities & Capital.
Net income on Page 18 Line 7-1 = Page 19 Line 43-2.
Administrative Salaries on Page 3 Line 17-1 = Page 21-A.
Management fees on Page 3 Line 17-3 = Page 21-B.
Professional fees on Page 3 Line 19-3 = Page 21-C.
Employee benefits/Payroll taxes on Page 3 Line 22-8 = Page 21-D.
Dues, etc. on Page 3 Line 20-8 = Page 21-F.
Travel expenses on Page 3 Line 24-8 = Page 21-G.